



DEPARTMENT OF VETERANS AFFAIRS

8320-01

38 CFR Part 17

RIN 2900-AO46

Authorization for Non-VA Medical Services

AGENCY: Department of Veterans Affairs.

ACTION: Final rule.

SUMMARY: This Department of Veterans Affairs (VA) rulemaking amends VA's regulations regarding payment by VA for medical services under VA's statutory authority for non-VA medical care. In the Federal Register on November 28, 2012, VA proposed to remove an outdated regulatory limitation on veterans' eligibility to be referred for non-VA medical care. On the same date, VA also published a companion direct final rule that would have made the same amendments effective on January 28, 2013, if no significant adverse comments were received. Because VA received adverse comments on the direct final rule, VA is withdrawing it in a companion document in this issue of the Federal Register. This rulemaking includes VA's responses to comments on the proposed and direct final rules.

DATES: Effective Date: This rule is effective [Insert date 30 days after date of publication in the FEDERAL REGISTER].

FOR FURTHER INFORMATION CONTACT: Lisa Brown, Chief, Policy Management Department, Department of Veterans Affairs, Chief Business Office, Purchased Care,

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SUPPLEMENTARY INFORMATION: On November 28, 2012, VA proposed a rule in the Federal Register, at 77 FR 70967, to amend its regulations authorizing non-VA medical care. Under our non-VA medical care authority in 38 U.S.C. 1703, VA may provide certain hospital care (inpatient care) and medical services (outpatient care) for eligible veterans when VA facilities are not capable of providing economical services due to geographical inaccessibility or are not capable of providing the services needed. VA proposed to revise its existing regulation, at 38 CFR 17.52(a)(2)(ii), to remove a limitation that barred VA from authorizing non-VA medical services for certain veterans who had not previously been furnished VA hospital care. Without this revision, these veterans were eligible for non-VA medical services under § 17.52(a)(2)(ii) to complete treatment of a nonservice-connected disability only if they had received VA hospital care for that disability.

On the same date, VA published a companion direct final rule at 77 FR 70893 that would have made the same amendments as those in the proposed rule effective on January 28, 2013, if no adverse public comments were received. The direct final rule and proposed rule each provided a 30-day comment period that ended on December 28, 2012. VA received comments on the proposed rule and direct final rule, including some adverse comments. VA is, therefore, withdrawing the direct final rule in a companion document in this issue of the Federal Register. VA addresses comments received on both the direct final and proposed rules in this action.

This final rule adopts the proposed rule without changes.

We received several comments urging VA to expand eligibility for non-VA medical care to allow all veterans the option of using the program for any needed treatment. VA lacks statutory authority to make this change. VA may provide non-VA medical care under 38 U.S.C. 1703 only in limited circumstances: When VA cannot provide economical hospital care or medical services because of geographic inaccessibility, or when VA facilities are not capable of providing the hospital care or medical services that a veteran needs. See 38 U.S.C. 1703(a). Further, if those conditions are met, VA has authority to provide non-VA medical care to a veteran only if the veteran meets the eligibility requirements set forth in section 1703. Thus, VA cannot make the changes these commenters request because to do so would be contrary to VA's statutory authority under 38 U.S.C. 1703.

One commenter who recommended that VA allow veterans to choose to receive care from private providers also stated that "VA hospitals should be for emergency care and for those who are having operations and need weeks or months to recover, such as multi-trauma cases," suggesting that all other care should be referred to non-VA providers. We emphasize that the VA health care system does provide emergency medical services and hospital care to eligible veterans, including surgical services and acute inpatient polytrauma rehabilitation, as recommended by the commenter. By statute, the VA health care system must also provide "a complete medical and hospital service for the medical care and treatment of veterans" (38 U.S.C. 7301(b)) and therefore cannot reduce the availability of VA care in the manner suggested by the commenter. VA makes no changes based on this comment.

One commenter expressed support for this regulation and stated that veterans receiving non-VA emergency treatment would not need to be transferred from a non-VA hospital to a VA hospital to complete treatment. This comment does not accurately characterize the effect of this rulemaking. To clarify, this action only applies to the provision of non-VA medical services after the veteran has received VA care and the non-VA medical services are needed to complete the VA care.

One commenter stated that VA should not “duplicat[e] medical services readily available by well qualified providers” and that “[m]any veterans are forced by current VA practices to utilize local medical services, even though the services are in theory available from the VA at other than a ‘local’ VA facility.” This comment can be interpreted in two ways. One interpretation is that some veterans are forced to pay for their own care from community providers in order to avoid traveling when their local VA facilities refer them to VA facilities located in other geographic areas. Another interpretation is that VA refers veterans to community providers when care would be better provided at a VA facility. Neither interpretation is within the scope of this rulemaking. VA therefore does not make any changes to this rulemaking based on these comments.

The same commenter recommended that veterans’ “expenses in utilizing [Medicare] should be offset by VA reimbursement.” We note that the VA health care system and Medicare are separate programs run under distinct statutory authorities. VA has no authority to reimburse Medicare beneficiaries for expenses they incur to obtain medical care under Medicare in the manner suggested by the commenter (see 42 U.S.C. 1395y(a)(3)). VA does not make any changes based on this comment.

One commenter asked whether this rulemaking would result in additional administrative burdens for veterans to obtain referrals or for providers to obtain payments for non-VA medical care. This rulemaking only removes a limitation; it does not create any new burdens or procedures. VA's regulations and policies pertaining to how veterans obtain referrals and how VA processes payments for non-VA medical care will remain the same. There will be no additional administrative burden on veterans or non-VA providers as a result of this rulemaking.

The majority of the comments that VA received on this rulemaking requested that VA allow hearing-aid specialists to perform diagnostic hearing evaluations for veterans. We received over one hundred comments on this issue. Some of the commenters requested to become recognized VA providers. VA allows only audiologists to perform such evaluations. We are not aware of any State that licenses hearing-aid specialists to perform such evaluations. VA will consider these comments internally as appropriate, but the request is outside the scope of this rulemaking, so we make no changes based on these comments.

VA received a comment expressing support for the proposed rule, but expressing concern about a draft request for proposals issued by VA for the procurement of non-VA medical care surgical services. This rulemaking affects only eligibility for non-VA medical services, and not VA's means of procuring such services. This comment, therefore, is outside of the scope of the regulation, and we make no changes based on it. VA will consider this comment in its evaluation of the draft request for proposals as appropriate.

VA received a comment expressing support for the proposed rule, but asking VA to remove “a burdensome regulatory requirement that prescriptions for veterans must be written by a VA-affiliated provider for the veteran to obtain the prescription at the VA’s discounted price. Instead, the VA should recognize the validity of a community-based physician’s prescription.” We do not make changes based on this comment because the issue is outside the scope of this regulation. VA will consider the recommendation internally as appropriate.

VA received one comment expressing support for the proposed rule and requesting that physicians certified by osteopathic boards of medicine be included in all VA activities concerning veterans’ healthcare. This comment is outside the scope of this regulation, but no change is required for VA to fulfill the request because VA considers doctors of osteopathic medicine as physicians, and does not distinguish between physicians based on their types of degrees.

VA received one comment stating “[v]ote no.” Since the commenter did not state a reason for disagreeing with this rulemaking, VA does not make any changes based on this comment.

In addition to the comments described above, VA received several comments expressing general support for the proposed rulemaking.

Based on the rationale set forth in the proposed rule and in this document, VA is adopting the provisions of the proposed rule as a final rule with no changes.

Effect of rulemaking

Title 38 of the Code of Federal Regulations, as revised by this final rulemaking, represents VA's implementation of its legal authority on this subject. Other than future amendments to this regulation or governing statutes, no contrary guidance or procedures are authorized. All existing or subsequent VA guidance must be read to conform with this rulemaking if possible or, if not possible, such guidance is superseded by this rulemaking.

Paperwork Reduction Act

This final rule contains no provisions constituting a collection of information under the Paperwork Reduction Act of 1995 (44 U.S.C. 3501-3521).

Regulatory Flexibility Act

The Secretary hereby certifies that this final rule will not have a significant economic impact on a substantial number of small entities as they are defined in the Regulatory Flexibility Act, 5 U.S.C. 601-612. This final rule directly affects only individuals and will not directly affect small entities. Therefore, pursuant to 5 U.S.C. 605(b), this amendment is exempt from the initial and final regulatory flexibility analysis requirements of 5 U.S.C. 603 and 604.

Executive Orders 12866 and 13563

Executive Orders 12866 and 13563 direct agencies to assess the costs and benefits of available regulatory alternatives and, when regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic,

environmental, public health and safety effects, and other advantages; distributive impacts; and equity). Executive Order 13563 (Improving Regulation and Regulatory Review) emphasizes the importance of quantifying both costs and benefits, reducing costs, harmonizing rules, and promoting flexibility. Executive Order 12866 (Regulatory Planning and Review) defines a “significant regulatory action,” requiring review by the Office of Management and Budget (OMB) as “any regulatory action that is likely to result in a rule that may: (1) Have an annual effect on the economy of \$100 million or more or adversely affect in a material way the economy, a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local, or tribal governments or communities; (2) Create a serious inconsistency or otherwise interfere with an action taken or planned by another agency; (3) Materially alter the budgetary impact of entitlements, grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) Raise novel legal or policy issues arising out of legal mandates, the President’s priorities, or the principles set forth in this Executive Order.”

The economic, interagency, budgetary, legal, and policy implications of this regulatory action have been examined, and it has been determined not to be a significant regulatory action under Executive Order 12866. VA’s impact analysis can be found as a supporting document at <http://www.regulations.gov>, usually within 48 hours after the rulemaking document is published. Additionally, a copy of the rulemaking and its impact analysis are available on VA’s Web site at <http://www1.va.gov/orpm/>, by following the link for “VA Regulations Published.”

Unfunded Mandates

The Unfunded Mandates Reform Act of 1995 requires, at 2 U.S.C. 1532, that agencies prepare an assessment of anticipated costs and benefits before issuing any rule that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of \$100 million or more (adjusted annually for inflation) in any one year. This final rule will have no such effect on State, local, and tribal governments, or on the private sector.

Catalog of Federal Domestic Assistance

The Catalog of Federal Domestic Assistance numbers and titles for the programs affected by this document are 64.007, Blind Rehabilitation Centers; 64.008, Veterans Domiciliary Care; 64.009, Veterans Medical Care Benefits; 64.010, Veterans Nursing Home Care; 64.011, Veterans Dental Care; 64.012, Veterans Prescription Service; 64.013, Veterans Prosthetic Appliances; 64.014, Veterans State Domiciliary Care; 64.015, Veterans State Nursing Home Care; 64.018, Sharing Specialized Medical Resources; 64.019, Veterans Rehabilitation Alcohol and Drug Dependence; 64.022, Veterans Home Based Primary Care; and 64.024, VA Homeless Providers Grant and Per Diem Program.

Signing Authority

The Secretary of Veterans Affairs, or designee, approved this document and authorized the undersigned to sign and submit the document to the Office of the Federal Register for publication electronically as an official document of the Department of

Veterans Affairs. Jose D. Riojas, Chief of Staff, Department of Veterans Affairs, approved this document on November 6, 2013 for publication.

List of Subjects in 38 CFR Part 17

Administrative practice and procedure, Alcohol abuse, Alcoholism, Claims, Day care, Dental health, Drug abuse, Government contracts, Grant programs-health, Government programs-veterans, Health care, Health facilities, Health professions, Health records, Homeless, Mental health programs, Nursing homes, Reporting and recordkeeping requirements, Veterans.

Dated: December 4, 2013.

Robert C. McFetridge.
Director, Regulation Policy and Management.
Office of the General Counsel,
Department of Veterans Affairs.

For the reasons stated in the preamble, the Department of Veterans Affairs amends 38 CFR part 17 as follows:

PART 17 – MEDICAL

1. The authority citation for part 17 continues to read as follows:

AUTHORITY: 38 U.S.C. 501, and as noted in specific sections.

2. Revise § 17.52(a)(2)(ii) to read as follows:

§ 17.52 Hospital care and medical services in non-VA facilities.

(a) * * *

(2) * * *

(ii) A veteran who has been furnished hospital care, nursing home care, domiciliary care, or medical services, and requires medical services to complete treatment incident to such care or services (each authorization for non-VA treatment needed to complete treatment may continue for up to 12 months, and new authorizations may be issued by VA as needed), and

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